What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

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SAI OF RELIEF

Prof Frederick Sai, Presidential Advisor on Reproductive Health, HIV/AIDS of the Republic of Ghana, is one of the architects of the Community Health and Family Planning Project. He has served as board member for several international organisations, including Family Health International, Family Care International, Population Action International, Population Council, and the International Planned Parenthood Federation…The "What works…" team paid a courtesy call on him at his residence in Accra. "What works…" notes 7, 8, and 9 are based on interactions with him.

WW: What Ghanaian programme has been most successful in addressing the issue of sexual and reproductive health and how can that programme be replicated throughout the country?

I would think that the Navrongo Experiment has probably been the most successful. Historically there have been preceding ones such as the Danfa project, which unfortunately was more for the benefit of the associates from outside the country than for those within the country. Although the programme was a very good one in concept and was executed well there wasn't the link up to the Ministry [of Health] to the extent that findings could be implemented and extended or disseminated and put within the system. The Navrongo one has been successful because it has been able to overcome this particular difficulty. Even though people like Jim Phillips and his associates have been involved, the programme has been made essentially Ghanaian owned and because it is Ghanaian owned, Ghanaians have been anxious to see to it that the lessons are applied as soon as they are learned. They are not even waiting for a final learning of all the lessons before applying them because even extending or disseminating the lessons of an experiment is still part of the experiment. The chain of referral or the chain of command is also very well oiled. The other aspect of this is the people's own beliefs about illness and what is permitted and not permitted in terms of their gods, spirits and ancestors. These are all taken into consideration far more sensibly than has happened in very many programmes that I have seen. Finally and most importantly service delivery is not time bound in terms of service. People are not told to come at eight o'clock in morning and be seen but people are seen when they have a need to be seen. A woman may be cooking but if she feels like going to see the nurse midwife at that time she goes and sees the nurse.

Policymakers and researchers are committed to improving women and children's health

Let me single out one activity that I think is so very important and that is the Community Health Midwife concept. If there is any staff person in community health particularly with respect to reproductive health and family planning that should be supported and trained well and supervised well and remunerated well it is the Community Health Midwife—Trained Midwife as against the Traditional Midwife. Trained Midwife is critical to the success of reproductive health particularly the Safe Motherhood programme because this is the sort of person who will be able to handle ordinary deliveries as and when they occur, where they occur or very close to where they occur. They will also be the ones to know signs, disturbing signs and identify them quickly. If they are supported with simple equipment such as a Motorola or cell phone system to call a base for transport in case of emergency, great results would be achieved—of course this provides that the emergency station is well equipped and well manned. But Navrongo has emphasised these and it has shown how to bring people into or involve them in their own health care delivery at reasonable cost and this has been documented.

WW: Are there any activities or policies that can best focus on the problems of maternal mortality, FGM, STDs, and HIV prevention for instance?

You want us to write a book! Well the first one is to have a reproductive health policy in which these things are identified. Such a policy should have a general developmental aspect and these specifics which are the ones being asked for. I have already talked about the general developmental aspects. Every girl should be educated at least seven years of in-school education, preferably more. Every woman, if she chooses to work, should be assisted to be gainfully employed. Gender violence for instance should be taken care of so that women feel confident in themselves. Specific

activities should ensure that women have children only when they want to have children. Women should know children do not have to come by accident. The services that should let women attain this kind of consciousness about when to have children and when not to have children should be provided as close to the women as possible and also made affordable. Alongside these services should be education on sexually transmitted diseases and their prevention accompanied by services for early diagnoses and treatment. For HIV/AIDS we know we still have got abstinence, fidelity in marriage and condom use as the only real approaches in our system. Then when we come to maternal mortality specifically we have got the approaches which can be community-based with trained personnel with back-up services. Community-based approaches means we should educate ourselves about what belief systems the people in the community have regarding pregnancy, what it takes for a pregnancy to come to term, childbirth and so on, and educate ourselves as to what the true situations are. I keep talking about the community because delays that cause maternal mortality start from there—delay in appreciating that something is wrong. In some of our communities a woman cannot go to the hospital by herself, a man has to be there. A pregnant woman has to seek her husband's permission to attend hospital. If the husband is not there what happens? So these are the things that we have to disabuse the minds of the community about.

Education—both formal and informal—is key to eradicating the practice of FGM. Here, adolescent girls learn livelihood skills

WW: Is it all then about attitudinal change?

Attitudes have to change for us to move forward but the system also has to be streamlined. We have to think in terms of a two-way transport and communication system from the community to the centre or to the backup service and vice-versa. Right here in Ghana some communities have arranged with private transport drivers so that when a card is shown a driver takes the woman to the nearest hospital or clinic for assistance without charging any fee—the fee will be dealt with later because this has been negotiated. We are therefore thinking of how you get care inside the community; identify the emergency as it happens, make arrangements for communication by cell phone of telephone, make arrangements for transportation and then see to it that there are trained physicians or trained assistants at the facilities which serve as the back-up system to receive such cases and deal with them because we think in obstetrics or in safe motherhood the deaths can occur very rapidly without your having any notice. So transportation to a point where service can be given is very, very important. The equipment and trained personnel at the facility is crucial—there must be adequate supply of antibiotics, transfusion fluids or even blood if possible.

Another area in which our women are dying is from the after effects of unsafe abortion. In some countries 30% of women who die from pregnancy-related causes are dying from unsafe abortion. There are laws covering abortion, some of these laws need to be looked at but whatever happens doctors need to be trained and equipped to handle unsafe abortion without being judgmental. We are not custodians of society's morality—we are custodians of society's health. We have to be moral, we may pass judgment sometimes but we shouldn't judge people when they need our services and so we have to train our doctors to handle any situation including infections, bleeding, retained products and so on. And when we have a comprehensive policy of handling sexually transmitted diseases, we should make this known and seek all possible help—train husbands and community members generally to recognize this need.

WW: How about female genital mutilation, are there any specific policies to address it?

FGM again relates to education and relates to the legal situation, but mainly education. This country has had a law since 1994 criminalizing FGM but some are running to the neighbouring countries to get it done, others are doing it quietly in their homes. If there are no side effects or complications people do not get to know. So education is the number one issue here. In terms of the law both those who cut and those who do the cutting should be made to know the law. In some countries what has happened is that the women who do the cutting—since this is part of their source of livelihood—are assisted to have another source of income, a more decent way of making a living. When they are given another source of livelihood then they are recruited into those who educate both the client and the public. In addition to our laws we should start thinking along those lines. Identify the people who do the cutting and get them to do other things that are more profitable."

Send questions or comments to: What works? What fails?
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